A biopsy was taken from the mass, which showed abundance of atypical lymphocytes mixed with plasma cells, small lymphocytes, histiocytes, eosinophils and some immunoblasts along with thrombosis and necrosis (Fig II) suggestive of polymorphic reticulosis. The patient was sent for radiotherapy and is under treatment. He has responded well to radiotherapy and nasal mass is regressed to 80%-90%.

DISCUSSION:

Nasal lymphomas previously caused great controversy with clinical and pathological debate. However, the situation is now clear and we now know that nasal T cell lymphomas are responsible for the slow progressive destruction of the nose and midfacial region by an apparent chronic inflammatory response. The disease most commonly presents with nasal obstruction, nasal discharge[2,4] and epistaxis[6]. The nasal mucosa is pale, friable and granular and is often accompanied by purulence and crusting. Oroantral fistulas frequently occur as a result of mucosal ulceration and palate necrosis[1]. Nasal septal perforation has been reported in 40% cases of nasal T cell lymphomas[2]. Systemic symptoms such as fever and weight loss are not typically noted except in advanced cases[4,5]. Systemic dissemination at the time on initial evaluation is seen in fewer than 10% of patients when it is present, it usually occurs in extranodal sites. Good quality biopsy material from tissue beneath the crust is essential. Peripheral T cell lymphomas possess an extremely heterogenous histological appearance. Histologically a mixed cellular infiltrate which consists of plasma cells, neutrophils and macrophages are demonstrated. Angiocentricity and angioinvasion are present with marked tissue ischemia and necrosis. The diagnosis depends on identification of atypical lymphoid cells. Immunohistochemistry and flow cytometry typically demonstrate the presence of the T cell associated marker CD2, CD7, CD45 RO and CD43[4]. Evidence of Epstein bar virus has been found in all nasal T cell lymphomas to date suggesting that the virus plays a causative role in the pathogenesis of these lesions[1,2,4]. Phenotypically nasal lymphomas differ from lymphomas that arise in the paranasal sinuses and in waldeyer's ring, the latter are predominantly B cell lymphomas[1].

Nasal T cell lymphomas respond well to local radiation therapy. Radical dose of 5500 cGy or more for wide sinonasal involvement is recommended. Death from this disease occurs in 50% of patients as a result of distant, extranodal spread or relapses that occur outside the treatment field[1,2,4]. Multiagent chemotherapy in combination with radiotherapy as the initial treatment approach is now recommended in an attempt to control the primary lesion as well as to prevent early dissemination[1]. If diagnosed and treated early, primary sinonasal lymphomas can be associated with a favourable outcome even with local treatment alone[6].

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Short Communications

A BULLET IN THE MAXILLARY SINUS

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Abstract: *Maxillary Sinus is an unusual site for lodgment of foreign bodies. We present a rare case of impacted bullet in the right maxillary sinus which entered through the orbital floor which could be removed after using a nasal endoscope through a Caldwell luc approach.*

Key words: *Maxillary sinus, bullet, foreign body*

INTRODUCTION

Foreign bodies in the maxillary sinus are uncommon. A variety of foreign bodies such as roots of teeth [1], dental impression material [2], matchsticks [3], wooden pieces [4] and sewing needle [5] have been reported. The route of entry is generally through an oroantra1 fistula or external trauma. The diagnosis of a foreign body in the maxillary sinus is generally secondary to a suspicion of symptoms of sinusitis following trauma, dental procedures and can be confirmed by radiological investigations such as X-ray and CT scan paranasal sinuses. We report and unusual case of a foreign body bullet lodged in the maxillary sinus.

**Graded specialist ENT, ** Classified Specialist ENT, Head of Department of ENT, ***Classified Specialist , & Air Force Hospital, Kanpur*

Fig.1: X-ray PNS Waters view

CASE HISTORY

Eighteen year old army recruit was referred with history of splinter injury right eye during firing. Patient presented with complaints of loss of vision in right eye and bleeding from right eye. There was no history of epistaxis or any other nasal complaints. On examination of the right eye there was a sclero-corneal tear with iris and vitreous prolapse and ecchymosis and hyphaema. There was no perception light in that eye. X-ray PNS Waters View done showed a foreign body in the right maxillary sinus (Fig.1) and patient was referred for an ENT opinion. ENT examination did not reveal any abnormality and there was no injury mark. Patient was further investigated with an X-ray lateral view of the skull which confirmed the presence of an irregular shaped foreign body in the right maxillary sinus. (Fig.2). A CT scan of the paranasal sinuses was done, which showed a bullet fragment impacted in the alveolar process of right maxilla (Fig.3). Patient was initially taken up for evisceration of he right eye in view of the high risk of sympathetic ophthalmitis and started on injections Cefotaxime, Gentamicin and Metrodinazole.

He was subsequently taken up for a Caldwell -Luc approach for removal of the foreign body. The right maxillary antrum was opened. However no foreign body was seen. With the help of 0 degree 4mm nasal endoscope the interior of the maxillary sinus was reexamined and a blackish coloured area was seen near the floor of the maxillary sinus which appeared like a haematoma. On probing its consistency felt hard and different from the antral wall. It was then re-visualised and appeared to be part of the bullet. With gradual manipulation with a Blakesely Wilde forceps passed alongside the endoscope through the incision the bullet was removed from the maxillary sinus. The size of the foreign body was found to be 1.4cm by .9cm.Post operatively, the patient was continued on intravenous antibiotics. His post operative recovery was uneventful and he was fitted with an artificial eye and discharged from the hospital after a week.

Fig.3: CT Scan Paranasal sinuses Coronal cut showing Foreign body implanted in right maxilla. The fracture in orbital floor and the FB are highlighted

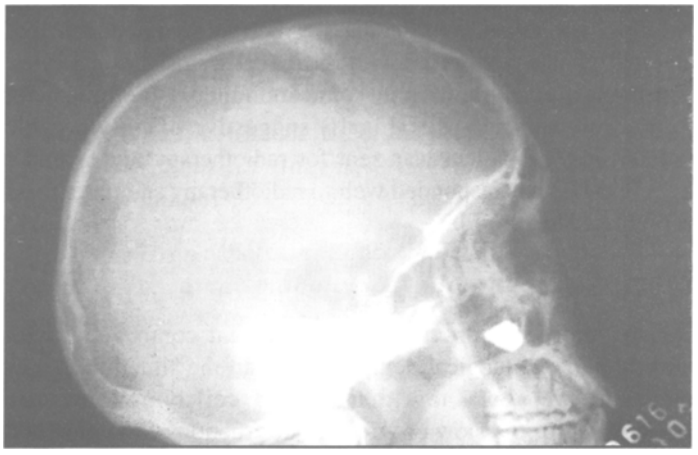

Fig.2: X-ray skull lateral view showing foreign body in right maxillary sinus

DISCUSSION

Different types of foreign bodies have been described in the paranasal sinuses. Of these foreign bodies are moe commonly lodged in the maxillary sinus than in the frontal [6], ethmoid and sphenoid sinuses [7] in the order of frequency. The common causes of foreign bodies in the maxillary sinus include (a) facial trauma (b) escape of teeth and dental impression through an oroantral fistula [8] and accidental loss of needles and matchsticks introduced through an oroantral fistula [5] iatrogenic causes such a foreign bodies due root filling procedures.

The peculair features in this case was the rarity of the foreign body, the path of its entry that is fracturing through the floor of the orbit and lodging into the maxillary antrum without causing any external injury. In this case the foreign body was also impacted in the alveolar process hence leading to difficulty in visualization and removal. Doing the preoperative CT scan and using an nasal endoscope was useful in knowing the exact position of the foreign body and helpful in its extraction in this case.

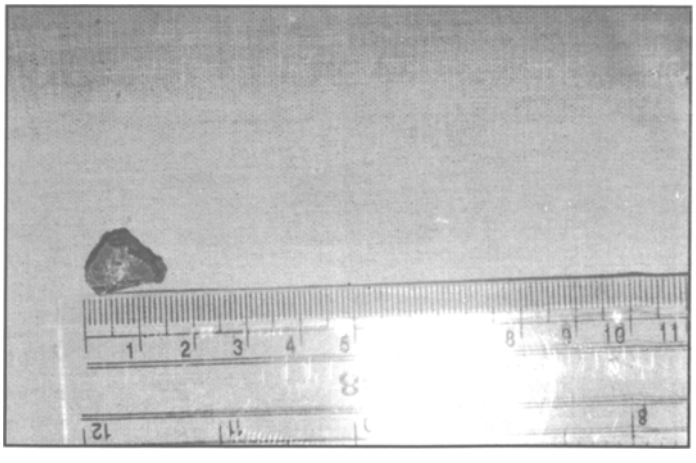

Fig.4: Removed fragment of bullet

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Short Communications

HOARSENESS - AS A PRESENTING FEATURE OF AORTIC ARCH ANEURYSM

John Mathai,* Swapna U.P.**

Abstract: *Hoarseness due to left recurrent laryngeal nerve paralysis (LRLN) caused by identifiable cardiovascular disease is described as Ortner's syndrome or Cardiovocal syndrome. This was first described by Ortner in 1897 to describe left recurrent laryngeal nerve palsy secondary to Mitral Stenosis. The common conditions which gave rise to Ortners' syndrome include mitral stenosis, mitral valve prolapse, aortic aneurysm, septal defect, following cardiothoracic surgery, high altitude pulmonary hypertension, ductal aneurysm, aortic dissection etc. Herewith we are presenting an unusual presentation of Aortic arch aneurysm.*

Key words: *Aortic arch aneurym, laryngeal nerve paralysis*

CASE REPORT

A 58 year old man presented to the Department of ENT Head and Neck Surgery, Medical College Hospital, Kottayam, with H/o change in voice of 1 ½ months duration and cough on drinking water. He is a non smoker , not diabetic and is on treatment for hypertension . Clinical examination revealed nothing but paralysis of the left of the left vocal cord and an ejection systolic murmur in the aortic area. Routine investigations were normal except for unfolding of aortic arch in the chest X-ray.

Patient was taken up for panedndoscopy/LA after cardiology consultation (S_1S_2-Normal; Grade II ejection systolic murmur in the aortic area.) Direct laryngoscopy revealed left vocal cord paralysis. Bronchoscopy, Oesophagoscopy and Nasal Endoscopy-Normal. Since no cause could be found out, he was advised CT Scan of the Nasopharynx, Neck and Upper chest. CT Scan showed a large Saccular dilatation of the arch of the aorta of about 7.56 cm towards left side with peripheral hypodensity (thrombus) of about 2.69cm. Peripheral rim of calcification noted

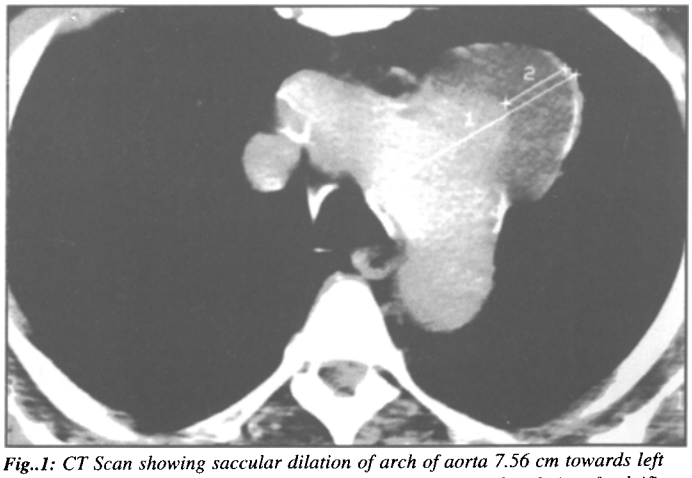

Fig..1: CT Scan showing saccular dilation of arch of aorta 7.56 cm towards left side withperipheral hypodensity of about 2.69 cm and peripheral rim of calcification around thrombus and arch of aorta

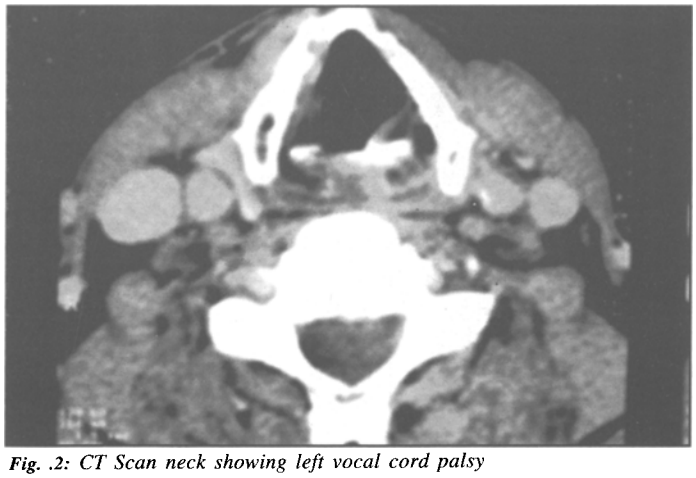

Fig. .2: CT Scan neck showing left vocal cord palsy

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